STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155149	B. WING			12/21/	2012
	PROVIDER OR SUPPLIE			8181 H	ADDRESS, CITY, STATE, ZIP CODE		
	JRT TERRACE NU	IRSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	REGULATORT OF	X ESC IDENTIF TING INFORMATION)		IAG	,		DATE
F0000	This visit was of Complaint: IN00120868 and Complaint: In Substantiated deficiencies reallegation are allegation are F312, F314. Complaint: In Substantiated deficiencies reallegation are F312, F314. Unrelated deficiencies reallegation are F312, F323, F312,	. Federal/State elated to the cited at F157, F282. N00120868 . Federal/State elated to the cited at F157, F282, N00121015 . Federal/State elated to the cited at F157, F282, F327. Ticiencies cited.	F0000	0	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credit Allegation and requests a Pos Survey Review on or after January 16, 2013. We respectf request an IDR for the state to consider the following deficiencies F282, F312, F323 be considered in deleting and reducing the scope and severi We are requesting a face to fa IDR discussion.	ot s n of ole t fully s to or ty.	DATE
	Provider Nun						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155149		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 12/21/	ETED	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		Fischer RN ype: Type: ncies reflect state in accordance with					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 2 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155149	B. WING		12/21/2012
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R	8181 H	IARCOURT RD	
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION	INDIAN	NAPOLIS, IN 46260	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0157	483.10(b)(11)	NOTO			
SS=E	NOTIFY OF CHA	NE/ROOM, ETC)			
	,	mediately inform the			
	•	with the resident's			
		known, notify the resident's			
		ive or an interested family			
	member when there is an accident involving the resident which results in injury and has				
the potential for requiring physician intervention; a significant change in the					
	resident's physical, mental, or psychosocial				
		erioration in health, mental,			
	•	status in either life			
	threatening conditions or clinical				
	complications); a	need to alter treatment			
		a need to discontinue an			
	•	reatment due to adverse			
		or to commence a new form			
		a decision to transfer or sident from the facility as			
	specified in §483				
		also promptly notify the			
		nown, the resident's legal rinterested family member			
		change in room or			
		nment as specified in			
	•	a change in resident rights			
		State law or regulations as			
	specified in para	graph (b)(1) of this section.			
	The facility must	record and periodically			
		ess and phone number of			
	the resident's leg	al representative or			
	interested family		F0157	E4F7 Notify of about	01/16/2013
		ervation, record	FU13/	F157 Notify of changes (injury/decline/room, etc)It is the	
	review and interview the facility			practice of this provider to	
	failed to imm	ediately inform a		immediately inform the resider	nt,
	resident's fam	ily member of a		consult with the resident' physician, and if known, notify	the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 3 of 86

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED	
		155149	B. WIN			12/21/2012	
		_			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	SR .		8181 H	ARCOURT RD		
HARCOL	JRT TERRACE NU	JRSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	change of co	ndition, and failed to			resident's legal representative	or	
	notify the res	ident's physician for a			an interested family member when there is an accident		
	change in condition which had the				involving the resident which		
	_				results in injury and has the		
	possibility of				potential for requiring physicia	n	
	intervention for 4 of 6 sampled				intervention; a significant cha		
	residents. [R	esidents "A", "F", "B"			in the resident's physical, men		
	and "E"].	11, 1, 5			or psychosocial status;a need		
	allu E J.				alter treatment significantly; or decision to transfer or discharge		
	Findings include:				the resident from the	Je	
					facility. What corrective		
					action(s) will be accomplishe	ed	
	1 Th	1 C D: 1 !! A !!			for those residents found to		
		d for Resident "A" was			have been affected by the		
	reviewed on	12-17-12 at 1:53 p.m.			deficient practice · Resident	4	
	Diagnoses in	cluded but were not			nolonger resides at the		
	_	conic obstructive			facility Resident F nolonger		
					resides at the facility. Residen nolonger resides at the	t B	
	pulmonary di	isease, congestive			facility Resident E nolonger		
	heart failure,	and hypertension.			resides at the facility How wil	ı	
	The resident	was admitted to the			you identify other residents		
		-25-12. These			having thepotential to be		
	_				affected by the same deficier	nt	
	diagnoses rer	nained current at the			practice and what		
	time of the re	cord review.			correctiveaction will be		
					taken? Residents with a char	-	
	A dusinai au an				of condition have thepotential	to	
		rders included Spiriva			be affected by the alleged deficient practice. Licensedst:	aff	
	[[a bronchodil	lator] 18 mcg			will be re-educated to physicia		
	[micrograms]	daily, Albuterol [a			and family/responsible		
	bronchodilator - anti asthmatic inhaler], Advair Diskus [a bronchodilator] two times a day.				partynotification related to		
					resident change of condition,	by	
					January 16, 2013 by the Staff		
					DevelopmentCoordinator/design	gne	
	The record al	so indicated the			e. Residents Change are reviewed for change of condit	ion	
		ived oxygen therapy at			in the morning		
	103Idelit 1000	ived oxygen merapy at			interdisciplinaryteam meeting		

STATEMENT OF DEFICE AND PLAN OF CORRECT	Î	X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 155149	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/21/2012
NAME OF PROVIDER OF		SING AND REHABILITATION	STREET A 8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD JAPOLIS, IN 46260	
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
2 liters [continued bedtime 11-25- In adding physical the nurres saturate 11-27 awake occation sic occation	per nase uous po e per ph 12." tion the an order sing star on level cord ind -12 at 10 and aler nal <sic (="" -12="" 4="" 4:="" <sic<="" [="" [%].=""]="" at="" bed="" copd="" disc="" ec;d="" i="" in="" nc="" nd="" ough.="" pary="" per="" pplied="" practition="" si="" sident="" t="" td="" wear=""><td>al canula and c-pap sitive air pressure] at ysician order dated resident had a r, dated 11-25-12 for ff to monitor oxygen ls every shift. icated the following: 0:36 p.m Resident tt. Resident had > nonprodective Resident has o2 iters/nasal cannuli rs c-pap at bedtime." 45 p.m Re;c <sic>hob [head of bed] truggling to breath 02 sat. between 83 Resident has HX. [chronic obstructive ease] on o2 at 2 l masal canula]. NP oner] notified, new less Assessment eezing noted. Resp</sic></td><td>IAG</td><td>Monday through Friday (excludinglys) to review for residentchange of condition physician notification. DNS/designee reviews the physician orders The Facility ActivityReport, Monday through Friday (excludinglys) for documentation supportthat physician/family been notified. The Nurse Manager on call is notified or acute change in condition on theweekend and holiday. DNS/Administrator is notified necessary.DNS/designee reviewed all residents charts ensure all change of condition were reported to the Physicia and Family. DNS/designee reviewed physician orders and The Facility Activity Report for documentation to support the physician/family have been notified Monday through Friday. The Nurse Manager call is notified of acute change condition on the weekends a holidays to ensure that family and physician have been notified. What measures with put into place or what systemicchanges you will make to ensure that the deficient practice does not recur Residents Change of condition is reviewed in the morning interdisciplinary teal meeting Mondaythrough Frice (excluding holidays) to reviewed resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resident change of condition (including vital signs out of resid</td><td>and and and luding to have f led as to ons an nd or at on ge in nnd y II be</td></sic>	al canula and c-pap sitive air pressure] at ysician order dated resident had a r, dated 11-25-12 for ff to monitor oxygen ls every shift. icated the following: 0:36 p.m Resident tt. Resident had > nonprodective Resident has o2 iters/nasal cannuli rs c-pap at bedtime." 45 p.m Re;c <sic>hob [head of bed] truggling to breath 02 sat. between 83 Resident has HX. [chronic obstructive ease] on o2 at 2 l masal canula]. NP oner] notified, new less Assessment eezing noted. Resp</sic>	IAG	Monday through Friday (excludinglys) to review for residentchange of condition physician notification. DNS/designee reviews the physician orders The Facility ActivityReport, Monday through Friday (excludinglys) for documentation supportthat physician/family been notified. The Nurse Manager on call is notified or acute change in condition on theweekend and holiday. DNS/Administrator is notified necessary.DNS/designee reviewed all residents charts ensure all change of condition were reported to the Physicia and Family. DNS/designee reviewed physician orders and The Facility Activity Report for documentation to support the physician/family have been notified Monday through Friday. 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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155149	B. WIN			12/21/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	CR CR			ARCOURT RD		
HARCOL	JRT TERRACE NU	JRSING AND REHABILITATION		INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	[respiratory t	herapist] here,			andPhysician and family/responsible		
		the c-pap done. Staff			partynotified. DNS/designee		
	spoke with fa	mily. Staff cont;d			reviews the physician orders a		
	<sic> to mon</sic>	itor o2 [oxygen] sat			Facility Activity ReportMonday through Friday (excluding	/	
		8 [%] - 91 [%]."			Holidays) for documentation to	0	
		(support that physician and		
		CO1 D :1 4			family/responsible party		
		6:01 a.m Resident			havebeen notified. The Nurs	е	
	resting in bed	l with c-pap machine			Manager on call is notified of acute change in condition on		
	on, o2 level r	ange between 88 - 91			theweekend and holiday to		
	when on c-pa	p. Resident was made			ensure that family and physici		
	_	and bed adjusted to			will be notified. Licensedstaff		
		·			be re-educated to physician and family/responsible	na	
		rway is open and			partynotification related to		
	resident is ab	le to breathe easily."			resident change of condition,	by	
					January 16, 2013 by the Staff		
	"11-29-12 at	2:18 p.m At about			DevelopmentCoordinator/desi e. Noncompliance with the	gne	
	9:00 a.m. res	ident was c/o			facility policy and procedures	may	
	[complains of	f] sob [shortness of			result inemployee education a		
		ter checked o2 sats 77			/or disciplinary action up to an including	d	
	1 -	ir] Resident had taken			termination. DNS/Designee to)	
	_	-			monitor compliance for		
	1	O2 was on res.			physician/family notification. H		
	[resident] O2	sat. increased to 93%			the corrective action(s) will b	e	
	on 2L O2. W	riter retrieved another			monitored toensure the deficient practice will not rec		
	nurse for mor	re advice, she said she			i.e., what quality assurance	ui,	
		Res. was also c/o			programwill be put into		
	c-pap machine not giving enough O2, res. had [family member] bring in c-pap machine from home,				place A Changeof Condition		
					tool will be utilized weekly x 4, monthly x 2, and		
					quarterlythereafter. · Ifthresho	ld	
					of 95% is not achieved, anact		
	[family mem	ber] connected c-pap			plan will be developed to achie	eve	
	machine and	res. said [resident]			desired threshold. Datawill be submitted to the CQI Committed.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155149			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/21/	ETED	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	P. Wal	STREET A	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	was cleaning I [family memb when [residen wanted to che family memb O2. After star informed that c-pap from ho resident et [far situation. Wri [resident] back machine et resident could Writer did VS w/n/l/ [within [blood pressur 82, R [respirat T. [temperatur for the Unit m c-pap straps. % and fading conscienceous pains. Writer more advice c	s <sic> et c/o chest retrieved NP for alled 911. Sent to area hospital] ER</sic>			for review and follow up. Compliance date: Janua 16, 2013	ry	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 7 of 86

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUIL		00	COMPL 12/21/	
		100110	B. WING		DDRESS, CITY, STATE, ZIP CODE	12/21/	2012
NAME OF P	PROVIDER OR SUPPLIER	2			ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1110		nd Tx. [treatment]."		1110			DITTE
	,	. ,					
	Review of the	record indicated the					
	physician orde	ered the c-pap for the					
	resident on 11-25-12. Although						
	review of a delivery form on						
	12-21-12 at 8:30 a.m., and dated						
	11-25-12, the record lacked						
	documentation the resident						
	received the continuous breathing						
	treatment until 11-27-12.						
	In addition, th	e record lacked					
	ŕ	n the physician was					
		arification of the					
	Albuterol orde						
		I the resident never					
		reatment. A review of					
		n administration					
		2012, indicated the					
	resident did no						
		ered medications in					
		pronchodilator's,					
	_	ed three treatments of					
		s and two treatments					
	for the Spiriva	1.					
	Further reviev	v of the record lacked					
	documentation	n the nursing staff					
	, -						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 8 of 86

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUILDING	00	12/21/2012
		100110	B. WING	ADDRESS, CITY, STATE, ZIP CODE	12/2 1/2012
NAME OF F	PROVIDER OR SUPPLIER	R		ARCOURT RD	
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION	INDIAN	APOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		m the physician the			
	oxygen saturation levels had not				
	been conducte	ed as ordered for each			
	nursing shift.				
	A review of th	ne Hospital record on			
	12-17-12 at 9:	00 a.m. indicated the			
	resident was a	ssessed with an			
	oxygen satura	tion level of 87 %,			
	diagnosed with pneumonia and				
	required respin				
		The emergency room			
		cated the resident had			
	complaints of				
	1 0 1	n and shortness of			
		inch, difficulty			
	_	night (off c-pap times			
	· ·	-pap last night but			
		reath worsened today.			
	_	breathing treatments			
	since at ECF [•			
	facility] times inspiratory and				
		rhonchi anterior."			
	wheezing and	monem antenut.			
	Interview on 1	12-17-12 at			
	approximately				
		nily member indicated			
		aff didn't get the c-pap			
		Part Ser May & Park			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 9 of 86

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL	
		155149	B. WIN			12/21/	2012
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION		8181 H	.ddress, city, state, zip code ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	they got it they use it. [Reside	ght away and once y didn't know how to ent] wasn't getting tments either."					
	reviewed on 1 Diagnoses inc limited to wea diabetic and n	for Resident "F" was 2-19-12 at 10:50 p.m. luded but were not kness, hypertension, europathy. These rained current at the cord review.					
	facility on 09- admission, the						
	1:01 p.m. the laothorgic <siction [and]="" [complete="" [medical="" bloometabolic="" do="" doctor="" duone<="" help="" project="" self="" td="" to=""><td>od count], bmp [basic file] c x r [chest xray]</td><td></td><td></td><td></td><td></td><td></td></siction>	od count], bmp [basic file] c x r [chest xray]					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 10 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012	
	ROVIDER OR SUPPLIER		8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD IAPOLIS, IN 46260	1 122112012
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	on 10-09-12 a	tes further indicated t 7:15 p.m. "lab			
	abnormal. Ne	esults came back ew order were given			
	Review of the physician orders indicated ua [urinalysis] c & s [culture and sensitivity]."				
	subsequent or which instruct oxygen satura middle of the [oxygen satura below 90 %.	taff received a der dated 10-10-12 ted them to take the tion level during the night to see if "sat ation level]" drops In and out cath] to obtain ua c & s."			
	10-10-12 at 1: "res. alert but eyes or mouth	nurses notes dated 53 p.m. indicated doesn't want to open a. res. wants to lay in ift and doesn't want to			
	Nurses note 1	0-10-12 at 3:56 p.m			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 11 of 86

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 12/21/	ETED	
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	<u>I</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE
	had an "witnes and although thit head the photo blood work." mild pulmonal congestion in fields. MD not check O2 sat a satisficated the vigive update or more lethargic night before, mild pulmonal congestion in fields. MD with following order place. O2 satisfieds in and out cather per MD." Nurses note 10 Rec;d <sic> receptorsive to responsive to resp</sic>	both lower lung of tified and order to and UA." D-10-12 at 9:19 p.m. write "called MD to a res. res was acting and out of it than the chest xray showing ry vascular both lower lung as notified and the ers were put into during middle of sat drops below 90 % at to obtain UA C & S D-10-12 at 9:39 p.m.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 12 of 86

	OF CORRECTION OF CORRECTION 155149	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	staff assist ed <sic> as needed, incontinent of bowel et bladder. Total care with ADL's [activities of daily living] refused medication vitals WNL no wheezing noted staff cont;d <sic> to monitor." Nurses note 10-11-12 at 5:53 a.m. "Resident in bed would no <sic> wake up to open eyes to take medication. No respond <sic> to tactile stimulation vitals WNL, will continue to monitor." Nurses note 10-11-12 at 11:56 a.m. "Resident in bed responsive to touch. Resident didn't eat or take any medication for this writer. Res. didn't open eyes or response <sic> to my voice. Called Md for instruction. writer was advised by the NP to call the family et advise them of the situation and see if they wanted [resident] to go to the hospital. Family said yes, send to [name of local area hospital] ER for eval et tx." A subsequent nurses note dated</sic></sic></sic></sic></sic>			
	them of the situation and see if they wanted [resident] to go to the hospital. Family said yes, send to [name of local area hospital] ER for eval et tx."			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 13 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155149		LDING	00	COMPL: 12/21/	
		100140	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	12/2 1/	2012
NAME OF P	PROVIDER OR SUPPLIEF	3			ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
	10-12-12 at 9:	58 a.m. indicated the					
	resident had been admitted to the						
	hospital and to	o the intensive care					
	unit.						
	Although the	nursing staff had					
	physician orde	ers for breathing					
	treatments, ox	tygen saturation level					
	and urinalysis	the nursing staff					
	failed to infor	m the physician the					
	orders had not	t been followed prior					
	to the resident	t being transported to					
	the hospital.						
	In addition, th	e record lacked					
	documentation	n the family had been					
	kept informed	of the continued					
	decline of the	resident's condition					
	until 10-11-12	2.					
		12-19-12 at 1:15 p.m.,					
		ator confirmed the					
		ers had not been					
	followed.						
		for Resident "B" was					
		2-17-12 at 1:30 p.m.					
	_	eluded but were not					
	limited to diat	oetes mellitus,					
	i		1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 14 of 86

	OF CORRECTION OF CORRECTION 155149	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIER URT TERRACE NURSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	pancreatic disorder, hypertension, traumatic brain injury, chronic obstructive pulmonary disease and hypertension. These diagnoses remained current at the time of the record review. Review of the nurses progress notes dated 11-22-12 at 2:50 p.m. indicated the "resident in bed at start of shift, resident not willing to get out of bed and expresses that [resident] is tired." Nurses note dated 11-22-12 at 4:17 p.m., indicated "resident in room			
	alert to name, response slow O2 sat 76 % O2 applied. Assessment done. [Name of physician] was call ed <sic> with result of blood sugar 366 et resident lethargic, [family member] yelling et send my baby to the hosp. [hospital]. 911 was called. Resident transferred to [name of local area hospital]." Interview with a concerned family member on 12-18-12 at 4:00 p.m., indicated, my [resident] called me,</sic>			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 15 of 86

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIEI JRT TERRACE NU	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	[resident]. The oxygen and not live [address a over 45 minuted I did get there bad, yes I told [resident] to the me for everyth know why the took [resident know how based over 45 minuted I discharged to 12-11-12 with which included tract infections.	arely understand aley had already started to one called me. I given] and it takes tes to get there. When the [resident] looked I them to send the hospital. They call thing else, and I don't they didn't call me. It I to call and let me the [resident] was." The hospital emergency on 12-17-12 at 9:15 I the resident had all status with a infection, bradycardia for was intubated and the provided to the the the the the provided to the the the the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 16 of 86

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID PREFIX TAG ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG IN addition when the resident was evaluated at the local area hospital emergency room on 11-22-12, the hospital record indicated the resident was assessed with "poor oral hygiene, diaper soaked in urine, diaper rash and small ulcer on testicle." Additional hospital notation dated 11-22-12 indicated the "patient was "unclean/has poor oral hygiene, poor skin condition/decubitus ulcers, ulcers on testicles, and extreme diaper rash." During record review on 12-19-12 at 9:30 a.m., the "shower report" dated 11-21-12 indicated the "street Address, CITY, STATE, ZIP CODE 8181 HARCOURT DD INDIANAPOLIS, IN 46260 (X5) COMPLETION CACHOORSETTIVE ACTION SHOULDE (X5) COMPLETION CACHOORSETTIVE ACTION SHOULDE (X5) COMPLETION CACHOORSETTIVE ACTION SHOULDE (CM) PRIFIX TAG PROVIDERS PLAN OF CORRECTION (CX5) COMPLETION CACHOORSETTIVE ACTION SHOULDE (CM) COMPLETION CACHOORSETTIVE ACTION SHOULDE (CM) CACHOORSETTIVE ACTION SHOULDE (CM) COMPLETION CACHOORSETTIVE ACTION CACHOORSETTI	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			A. BUILDING B. WING	CONSTRUCTION 00	COM 12/2	TE SURVEY PLETED 21/2012
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) In addition when the resident was evaluated at the local area hospital emergency room on 11-22-12, the hospital record indicated the resident was assessed with "poor oral hygiene, diaper soaked in urine, diaper rash and small ulcer on testicle." Additional hospital notation dated 11-22-12 indicated the "patient was "unclean/has poor oral hygiene, poor skin condition/decubitus ulcers, ulcers on testicles, and extreme diaper rash." During record review on 12-19-12 at 9:30 a.m., the "shower report"				8181	HARCOURT RD	DE	
evaluated at the local area hospital emergency room on 11-22-12, the hospital record indicated the resident was assessed with "poor oral hygiene, diaper soaked in urine, diaper rash and small ulcer on testicle." Additional hospital notation dated 11-22-12 indicated the "patient was "unclean/has poor oral hygiene, poor skin condition/decubitus ulcers, ulcers on testicles, and extreme diaper rash." During record review on 12-19-12 at 9:30 a.m., the "shower report"	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE	COMPLETION
resident had "redness and raw" noted. The comment section of this report indicated "redness with no open areas." Interview on 12-19-12 at 1:10 p.m. the Assistant Director of Nurses indicated the physician should have been notified for a treatment order. "I was not made aware that on 11-21-12 the		evaluated at the emergency roshospital recorresident was a oral hygiene, urine, diaper non testicle." Additional hour 11-22-12 indi "unclean/has poor skin confucers, ulcers extreme diaper to the sextreme d	he local area hospital om on 11-22-12, the d indicated the assessed with "poor diaper soaked in rash and small ulcer spital notation dated cated the "patient was poor oral hygiene, dition/decubitus on testicles, and er rash." I review on 12-19-12 he "shower report" 2 indicated the redness and raw" omment section of licated "redness with" Interview on 10 p.m. the Assistant urses indicated the uld have been notified at order. "I was not				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 17 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155149	B. WIN			12/21/	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		or raw. If I had know,					
	yes it would have required the						
	doctor to be notified for a treatment order."						
	4. The record for Resident "E" was reviewed on 12-18-12 at 10:30 a.m.						
		eluded but were not					
	_	piratory failure,					
	_	art failure, chronic					
	_						
	1	ılmonary disease, and					
	anoxic injury.						
		e resident had a					
	"	eeding tube, an					
	indwelling cat	theter, a rectal tube					
	and a tracheos	stomy.					
	These diagnos	ses remained current					
		the record review.					
		one record review.					
	Observation o	on 12-18-12 at 1:35					
	p.m., the resid	lent was observed for					
	_	nent. With the					
		urses in attendance					
		nurse employee #3 the					
		1 2					
		urned to the right					
		ation at this time, the					
		ncontinent of stool					
	and a saturate	d dressing was					
	I						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 18 of 86

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			LE CO	ONSTRUCTION 00	(X3) DATE (COMPL 12/21/	ETED
	PROVIDER OR SUPPLIEI JRT TERRACE NU	RSING AND REHABILITATION	81	81 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	observed on the resident's left	he posterior of the thigh.					
	notes, dated 1 indicated the area covered who buttock cheek however with breakdown." nursing admis dated 12-17-1 indicated the area covered with breakdown.	Review of the ssion assessment, 2 at 3:20 p.m., also resident had a e - left buttock cheek."					
	Admission Ca 12-17-12 at 3: resident "has a integrity (loca cheek." Inter- care included [medical doct	are Plan," dated 35 p.m., indicated the actual impaired skin ation) left buttock wention to this plan of "notify the MD or] as needed."					
	the physician until 12-18-12 the Director o	for a treatment order 2 at 1:00 p.m., when f Nurse indicated the scribed "Calmoseptine					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 19 of 86

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIED	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	every shift an	d as needed."			
	resident was a feeding tube a for a "free wa	pon admission the assessed with a and physician orders ter boluses 400 ml very six hours."			
	administration the nurse tran 200 ml every on 12-19-12 a nurse employ order as "200	of the medication in record [12-2012], scribed the order as six hours. Interview at 8:25 a.m., licensed ee #7 verified the c.c. [cubic every 4 hours."			
	a.m., with the attendance the again assessed resident's cath and appeared Interview on the Director of color of the relation o	on 12-19-12 at 9:55 Director of Nurses in e resident's skin was d. The urine in the neter tubing was dark concentrated. 12-19-12 at 1:00 p.m., of Nurses verified the esident's urine. nursing staff failed to fy the physician order darification of the free			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 20 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVE COMPLETED	ΞΥ	
AND FLAN	OF CORRECTION	155149		LDING	00	12/21/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION		
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIAT		E	PLETION DATE
	water boluses.						
	5. Review of	the facility policy on					
	12-19-12 at 8:45 a.m., titled						
	"Resident Cha	inge of Condition,"					
	and dated as re	evised 3/10 [March					
		ed the following:					
	"POLICY [bold type] It is the						
	policy of this facility that all						
	changes in res	ident condition will					
	be communica	ated to the physician					
	and family/res	ponsible party, and					
	that appropria	te, timely and					
	effective inter	vention occurs."					
	"PROCEDUR	E - 2. Acute Medical					
	Change - a. A	any sudden or serious					
	change in a re	sident's condition					
	manifested by	a marked change in					
	physical or me	ental behavior will be					
	communicated	l to the physician					
	with a request	for physician visit					
	promptly and/	or acute care					
	evaluation. The	he licensed nurse in					
	charge will no	tify the physician. c.					
	The responsib	le party will be					
	notified that the	nere has been a					
	change in the	resident's condition					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 21 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 12/21/	ETED
		100110	B. WIN		DDRESS, CITY, STATE, ZIP CODE	12,21,	2012
NAME OF F	PROVIDER OR SUPPLIER			1	ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIANA	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		s are being taken. 3.		1110			5.112
	•	cal Change - a. All					
		l unusual signs will					
		d in the medical					
	record and cor	nmunicated to the					
	attending phys	sician promptly.					
		ges are a minor					
	change in phy	sical and mental					
	behavior, abnormal laboratory and						
	x-ray results that are not life						
	threatening. b. The nurse in charge						
	is responsible	for notification of					
	physician and	family/responsible					
	party prior to	end of assigned shift					
	when a signifi	cant change in the					
	resident's cond	dition is noted. f.					
		ident change of					
		response in the					
		d. Documentation					
	will include ti						
		ian response. g. The					
		responsible for the					
		ontinue assessment					
		ation in the medical					
	record every s						
	resident's cond	lition has stabilized."					
	This Endorel +	na ralotas to					
	This Federal to complaints IN	_					
	Compianits IIV	00120799,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 22 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIES X1) PROVIDER/SUPPLI	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/21/2012		
	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION		
	IN00120868 and IN00121015.					
	3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 23 of 86

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149 NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			ETED		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
F0282 SS=G	CARE PLAN The services provide facility must be propersons in accord written plan of care. Based on obserview and interview and interview and interventions of care and/or were followed lacked of respiratory disadmission to the medications, the testing, physical needs, wound needs for 6 of [Resident's "A and "C"]. Findings inclusion. 1. The record reviewed on 1 Diagnoses incolumnited to chropulmonary disagraphs.	ervation, record ferview the facility re the resident's plan physician orders which included iratory therapy which included stress with hospital he hospital, lack of reatments, laboratory sian referral, hygiene care and hydration 6 sampled resident's. ", "F", "B", "D", "E"	F02	82	F282 Comprehensive Care Plans This provider ensures the services provided or arranged the facility is provided by qualipersons in accordance with earesident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident A no lon resides at the facility Resident B no longer resides at the facility Resident B no longer resides at the facility Resident B no longer resides at the facility Resident C's care plan updated and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident care sheet updated. Resident E no longer resides at the facility Resident C acre plan and resident C acre plan and resident C acre plan and resident care sheet updated and resident	by fied ach ger nt F at ts d at eet ow nts	01/16/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 24 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLE	TED
		155149	B. WIN			12/21/2	2012
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The resident v	was admitted to the			be affected by the alleged deficient practice. Licensed		
	facility on 11-25-12. These			staff will be re-educated on			
	diagnoses rem	nained current at the			nursing admission/return		
	time of the red				admission procedure, change	of	
	unite of the fed	cold leview.			condition, physician orders and		
					care plans by January 16, 201	3	
	Admission or	ders included Spiriva			by the Staff Development		
	[a bronchodila	-			Coordinator/designee. The Facility Activity report, physicia	an	
	-	- •			orders and new	•	
		daily, Albuterol [a			admissions/re-admissions are	,	
	bronchodilator - anti asthmatic inhaler], Advair Diskus [a				reviewed in the morning		
					interdisciplinary team meeting		
	bronchodilato	r] two times a day.			ensure services are provided	per	
					plan of care · DNS/designee reviews the physician orders a	and l	
		so indicated the			The Facility Activity Report to	iiiu	
	resident receive	ved oxygen therapy at			ensure services are provided	per	
	2 liters per na	sal canula and c-pap			plan of care. What measures		
	_	ositive air pressure] at			will be put into place or what	:	
	1 - 1	• -			systemic changes you will		
		hysician order dated			make to ensure that the		
	11-25-12."				deficient practice does not		
					recur? · Licensed nurses hav	e	
	In addition the	e resident had a			been re-educated by the SDC/designee on accurate		
					reading of Physician's orders a	and	
	^ -	er, dated 11-25-12 for			transcription to the MAR/TAR		
	the nursing sta	aff to monitor oxygen			Resident Needs sheets by		
	saturation leve	els every shift.			January 16, 2013. · All copies		
		3			physician orders will be check		
	T1 1 ·	1:			for transcription errors by Nurs	se	
	I he record inc	dicated the following:			Managers during clinical meeting. Weekly audits of		
					MAR's/TAR's will be complete	d	
	"11-27-12 at 1	10:36 p.m Resident			by Nurse Managers · The IDT		
		ert. Resident had			will review the physician order		
					the clinical meeting. The IDT		
ı	occational <si< td=""><td>c> nonprodective</td><td></td><td></td><td>determines if further intervention</td><td></td><td></td></si<>	c> nonprodective			determines if further intervention		
	<sic> cough.</sic>	Resident has o2			or changes to the plan of care	IS	
					necessary. · All admissions		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETE	ED
		155149	B. WIN			12/21/20	12
NAME OF B	NOTABLE OF CLIBBLIES			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			8181 H	ARCOURT RD		
	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re Co	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	orders are to be verified by		DATE
		liters/nasal cannuli			Nurses. · Staff who are		
	<sic> and wea</sic>	rs c-pap at bedtime."			noncompliant may be		
					re-educated and /or receive		
	"11-28-12 at 4:45 p.m Re;c <sic></sic>				disciplinary action up to and including termination. • Director	or	
	resident in bed	hob [head of bed]			of Nursing/designee is to moni		
		struggling to breath			for compliance.Rounds will be conducted by DNS/designee of		
	_	O2 sat. between 83			all shifts to ensure the care pla		
		Resident has HX.			are followed regarding hydratic		
					needs, respiratory intervention	S,	
	* =	Chronic obstructive			hygiene needs and wound care.MAR/TAR's will be review	und	
	-	sease] on o2 at 21			by DNS/designee to ensure	/eu	
	[liters] per nc	[nasal canula]. NP			medications, treatments, wour	ıd	
	[nurse practiti	oner] notified, new			care and labs are being provid		
	order rec;d <s< td=""><td>ic> Assessment</td><td></td><td></td><td>as prescribed. The Facility Acti</td><td></td><td></td></s<>	ic> Assessment			as prescribed. The Facility Acti		
	, ,	heezing noted. Resp			report, physician orders and no admissions/re-admissions are		
	[respiratory th	•			reviewed in the morning		
	- 1	1 1 /			interdisciplinary team meeting		
		ne c-pap done. Staff			ensure services are provided plan of care. The Manager on		
	_	nily. Staff cont;d			Duty/desginee will review the		
	<sic> to moni</sic>	tor o2 [oxygen] sat			review facility activity report ar		
	[saturation] 88	3 [%] - 91 [%]."			new admission/re-admissions	on	
	-				the weekends. How the		
	 "11 20 12 ot 6	5:01 a.m Resident			corrective action(s) will be monitored to ensure the		
					deficient practice will not rec	ur	
	_	with c-pap machine			i.e., what quality assurance	u,	
	on, o2 level ra	nge between 88 - 91			program will be put into plac		
	when on c-pap	o. Resident was made			· An admission/re-admission (
		nd bed adjusted to			and Care Plan updating CQI w	/III	
		way is open and			be utilized weekly x 4, and monthly x2, quarterly thereafte	r.	
					The CQI committee will review		
	resident is abl	e to breathe easily."			the data collected. If a 95%		
					threshold is not achieved, an		
	"11-29-12 at 2	2:18 p.m At about			action plan will be developed. Compliance date: January 16	,	
			ı		Compliance date. January 10	,,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 26 of 86

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	A. BUIL	LDING	NSTRUCTION 00	(X3) DATE : COMPL 12/21/	ETED
	PROVIDER OR SUPPLIER		B. WING	STREET A	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	<u> </u>	
(X4) ID PREFIX	SUMMARY S' (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
PREFIX TAG	9:00 a.m. reside [complains of breath]. Write % ra [room air off O2, once O [resident] O2 on 2L O2. Write on 2L O2. Write on one of one	lent was c/o sob [shortness of er checked o2 sats 77] Resident had taken		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION DATE
	_	m. CNA [certified ormed writer that					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 27 of 86

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUIL		00	COMPL 12/21/	
		100110	B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE	12/2 !/	
NAME OF F	PROVIDER OR SUPPLIER	8			ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ŀ	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
		not breathe well.					
	Writer did VS [vital signs] all						
	w/n/l/ [within	normal limits] BP					
	[blood pressur	re] 138/72, P [pulse]					
	82, R [respirat	tions] 24 O2 sat 93 %					
	T. [temperatu	re] 97.6 Writer asked					
	for the Unit m	anager to help with					
	c-pap straps.	Res. was sating at 96					
	% and fading	in et out of					
	conscienceous <sic> et c/o chest</sic>						
	pains. Writer	retrieved NP for					
	more advice c	alled 911. Sent to					
	[name of local	l area hospital] ER					
	[emergency ro	oom] for eval					
	[evaluation] a	nd Tx. [treatment]."					
	Daview of the	record indicated the					
		ered the c-pap for the					
	1 ~ ~	-25-12, the record					
		entation the resident					
		ontinuous breathing					
		1 11-27-12. In					
	addition, the r						
		n the physician was					
		arification of the					
	Albuterol orde						
		the resident never					
		reatment. A review of					
		n administration					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 28 of 86

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET A 8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEPICIENCY)	(X5) COMPLETION DATE
TAG	record for 11- resident did no physician order regard to the be which include Advair Diskus for the Spiriva Further review documentation failed to infort oxygen satura been conducte nursing shift. A review of the 12-17-12 at 93 resident was a oxygen satura diagnosed with required respicient expicient intervention. physician indic complaints of epigastric pair breath since be breathing last	2012, indicated the of receive the ered medications in pronchodilator's, d three treatments of a and two treatments a. It of the record lacked in the nursing staff in the physician the tion levels had not ed as ordered for each in the expectation of the expec	TAG	DEFICIENCY)	DATE
	shortness of b	reath worsened today.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 29 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155149	B. WIN			12/21/2	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HARCOL	IRT TERRACE NI IE	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260		
					AI OLIO, IN 40200		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	Not receiving	breathing treatments					
	since at ECF [•					
	facility] times						
	inspiratory and	•					
	wheezing and	rhonchi anterior."					
	 T	2 17 12 4					
	Interview on 1						
	approximately	•					
		nily member indicated					
	the nursing sta	off didn't get the c-pap					
	machine in "ri	ght away and once					
	they got it they	y didn't know how to					
	use it. [Reside	ent] wasn't getting					
	breathing treat						
	2 The record	for Resident "F" was					
		2-19-12 at 10:50 p.m.					
		luded but were not					
	· ·						
		kness, hypertension,					
		europathy. These					
	_	ained current at the					
	time of the rec	cord review.					
	The resident w	vas admitted to the					
	facility on 09-	01-12. At the time of					
	·	resident required					
		th bathing, dressing					
	and toileting a						
	assistance with						
	assistance with	ii iiiooiiity.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 30 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	ILTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	155149	A. BUIL		00	COMPL: 12/21/	
		100140	B. WING		ADDRESS, CITY, STATE, ZIP CODE	12/2 1/	2012
NAME OF I	PROVIDER OR SUPPLIER	ł			ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG	REGULATORT OR	LISC IDENTIFY FING INFORMATION)		IAG	,		DATE
	The record inc	dicated on 10-09-12 at					
1:01 p.m. the "resident has been							
		c> this shift, not able					
		anything, Md					
	[medical doct	· ·					
	-	od count], bmp [basic					
	- 1	file] c x r [chest xray]					
	et [and] duone						
	therapy] three times a day times 3						
	days."	times a day times 5					
	days.						
	The nurses no	tes further indicated					
		t 7:15 p.m. "lab					
		esults came back					
	-	ew order were given					
	"	W order were given					
	•••						
	Review of the	physician orders					
		urinalysis] c & s					
	_	• -					
	[culture and se	znstivity].					
	The nursing st	taff received a					
	_	der dated 10-10-12					
	_	ted them to take the					
		tion level during the					
		night to see if "sat					
		ation level]" drops					
	deiow 90 %	In and out cath					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 31 of 86

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155149	A. BUILDING B. WING		12/21/2012
	PROVIDER OR SUPPLIEF	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE HARCOURT RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	[catherization] to obtain ua c & s."			
	10-10-12 at 1: "res. alert but eyes or mouth	nurses notes dated 53 p.m. indicated doesn't want to open a. res. wants to lay in ift and doesn't want to			
	as a late entry had an "witne and although hit head the pl blood work. ' mild pulmona congestion in	both lower lung otified and order to			
	indicated the give update or more lethargic night before. mild pulmona congestion in fields. MD w	0-10-12 at 9:19 p.m. write "called MD to n res. res was acting and out of it than the chest xray showing ry vascular both lower lung as notified and the ers were put into			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 32 of 86

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE : COMPL	
		155149	A. BUI B. WIN	LDING		12/21/	
			b. Will		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	{		8181 HA	ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		during middle of		mo			DATE
	_	•					
	night to see if sat drops below 90 % in and out eath to obtain UA C & S						
		ii to obtain OA C & S					
	per MD."						
	Nīmes - 1	0.10.10 -4.0-20 -					
		0-10-12 at 9:39 p.m.					
	Rec;d <sic> re</sic>	<i>'</i>					
	_	tactile stimulation.					
Resident only took sip of water							
encouragement given. Refused diet							
		<sic> as needed,</sic>					
	incontinent of	bowel et bladder.					
	Total care wit	h ADL's [activities of					
	daily living] r	efused medication					
	vitals WNL no	o wheezing noted					
	staff cont;d to	monitor."					
	N T 4 1	0 11 12 4 5 52					
		0-11-12 at 5:53 a.m.					
		ed would no <sic></sic>					
		en eyes to take					
		o respond <sic> to</sic>					
		tion vitals WNL, will					
	continue to m	onitor."					
		0-11-12 at 11:56 a.m.					
		ed responsive to					
	touch. Reside	ent didn't eat or take					
	any medicatio	n for this writer. Res.					
	didn't open ey	es or response <sic></sic>					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 33 of 86

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIE	R	8181 H	ADDRESS, CITY, STATE, ZIP CODE IARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	instruction. v the NP to call them of the si wanted [resid hospital. Fan [name of loca eval et tx." A subsequent 10-12-12 at 9 resident had b	Called Md for vriter was advised by the family et advise tuation and see if they ent] to go to the nily said yes, send to I area hospital] ER for nurses note dated :58 a.m. indicated the een admitted to the o the intensive care			
	physician ord treatments, or and urinalysis failed to infor orders had no to the residen- the hospital. In addition, the documentation kept informed	nursing staff had ers for breathing tygen saturation level the nursing staff m the physician the t been followed prior t being transported to the record lacked in the family had been the formulation of the continued resident's condition 2.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 34 of 86

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUI	LDING	00	COMPL 12/21/	
		130149	B. WIN		DDDEGG CITY OT TE ZID CODE	12/21/	2012
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		12-19-12 at 1:15 p.m.,					
	the Administra	ator confirmed the					
	physician orde	ers had not been					
	followed.						
	3. The record for Resident "B" was						
	reviewed on 1	2-17-12 at 1:30 p.m.					
		luded but were not					
	limited to diabetes mellitus,						
		order, hypertension,					
	_	n injury, chronic					
		Ilmonary disease and					
	_	These diagnoses					
	. –	ent at the time of the					
	record review						
	record review						
	The clinical re	ecord indicated the					
	resident had fl	luctuating capillary					
		levels, and on					
		ohysician instructed					
	the nursing sta						
	Endocrinologi						
	Ziidooiiiioiogi						
	The resident's	blood glucose levels					
		luctuate through					
		en the resident was					
		al area hospital for					
	evaluation.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 35 of 86

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIE	R IRSING AND REHABILITATION	8181	ADDRESS, CITY, STATE, ZIP CODE HARCOURT RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	documentation referred to the evaluation and Review of the data set assess indicated the extensive assishygiene and vincontinent. The resident's 10-04-11 india a "self care dotthis "problem "resident will groomed and daily" Interventions care as needed least two times shower two times shower two times and the subsequents.	plan of care dated			
	08-12-12 indi	cated "problem -			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 36 of 86

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SU COMPLET	
THIND TEAM	or condition	155149	A. BUII B. WIN	LDING		12/21/20	
NAME OF E	PROVIDER OR SUPPLIER	,	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
					ARCOURT RD		
		RSING AND REHABILITATION	_		APOLIS, IN 46260		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	((X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE .	DATE
	resident has h	_ ,					
	impaired skin integrity to lt. [left]						
	ankle and rt. [- -					
		to this plan of care					
		fy MD of worsening					
	_	n wound or for signs					
	· ·	ncontinent care as					
	needed, assess wound weekly						
	documenting measurements and						
	description, observe for signs of						
		ness, pain, drainage,					
	malodorous di	-					
	increase in siz	e/depth of wound."					
	When the resid	dent was evaluated at					
		hospital emergency					
		2-12, the hospital					
		ed the resident was					
	assessed with	"poor oral hygiene,					
	diaper soaked	in urine, diaper rash					
	and small ulce	er on testicle."					
		spital notation dated					
		cated the "patient was					
	_	poor oral hygiene,					
	_	dition/decubitus					
	· ·	on testicles, and					
	extreme diape	r rash."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 37 of 86

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE : COMPL	
		155149	A. BUII B. WIN	LDING G		12/21/	
NAME OF F	DDOVIDED OD CLIDDI IED		B. WIIV		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	PROVIDER OR SUPPLIER				ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	During record	review on 12-19-12					
	at 9:30 a.m., tl	he "shower report"					
	dated 11-21-1	2 indicated the					
	resident had "	redness and raw"					
	noted. The co	omment section of					
	this report ind	icated "redness with					
		." Interview on					
		10 p.m. the Assistant					
	Director of Nurses indicated the						
	physician should have been notified						
	for a treatmen	t order. "I was not					
	made aware th	nat on 11-21-12 the					
	area was red o	or raw. If I had know,					
	yes it would h	ave required the					
	doctor to be no	otified for a treatment					
	order."						
	4 551 1	0 D 11 HDH					
		for Resident "D" was					
		2-19-12 at 9:40 a.m.					
	_	luded but were not					
		nemic heart disease,					
		mentia, coronary					
	-	, hypertension, and a					
	_	. These diagnoses					
		ent at the time of the					
	record review						
	The record in	licated the resident					
	was neated by	a local wound care					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 38 of 86

	OF CORRECTION OF CORRECTION 155149	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	company. The record indicated the resident had a plan of care dated 11-21-12 which indicated the "resident was at risk for skin breakdown due to impaired mobility, slides down in chair/bed, diabetes, heart disease, incontinence, confusion, anemia and pressure area to the sacrum." Interventions to this plan of care included "preventative treatment as ordered."	TAG	Datement	DATE
	Review of a physician order dated 12-07-12 instructed the nursing staff to "cleanse sacrum with normal saline and pat dry, apply calo [calmoseptine] to periwound, santyl to wound bed, cover with gauze, secure with tape, change daily and prn [as needed]." The resident was assessed by the local wound care specialist on 12-14-12 and indicated a change in the "plan - Cleanse wound bed with normal saline and pat dry. Apply barrier cream to periwound. Santyl			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 39 of 86

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 12/21 /	ETED
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	p. with	STREET A	ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	to wound bed followed by hydrogel moistened, fluffed gauze, then cover with dry gauze and secure daily and PRN soiled."						
	a.m., licensed indicated she	n 12-19-12 at 10:30 nurse employee #8 was preparing to dressing change to the sure ulcer.					
	fully dressed. with the help resident to the slacks to ankle of the incontinuthe resident's	ying on back in bed The licensed nurse of a CNA turned the right side, pulled es, removed one side nent brief, exposing buttocks. The ot have a dressing to					
	around the prewith a gauze version soaked in normal then applied the	essure ulcer two times which had been mal saline. The nurse he Santyl followed by and a dry dressing red with tape.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 40 of 86

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUILE		00	COMPL 12/21/	
		100110	B. WING		ADDRESS, CITY, STATE, ZIP CODE	12,21,	2012
NAME OF F	PROVIDER OR SUPPLIER	1			ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
TAG	REGULATORT OR	LSC IDENTIFFING INFORMATION)		IAU			DATE
	Review of the	medication/treatment					
record for 12-2012, contained the							
		12-07-12 and not the					
	current order from the wound care specialist.						
	5. The record for Resident "E" was						
		2-18-12 at 10:30 a.m.					
	Diagnoses included but were not						
	_	piratory failure,					
	_	art failure, chronic					
	_	lmonary disease, and					
	anoxic injury.						
		e resident had a					
	,	eeding tube, an					
		heter, a rectal tube					
	and a tracheos	ctomy.					
	These diagnos	ses remained current					
		the record review.					
	at the time of	the record review.					
	Review of the	"Temporary					
		re Plan," dated					
		35 p.m., indicated the					
		potential for fluid					
		ated to] risk factor					
	identified on h						
		Interventions to the					
	assessificite.	inition to the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 41 of 86

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE A. BUILDING	CONSTRU 00		(X3) DATE : COMPL 12/21/	ETED
		100140	B. WING	ET ADDDES	SS, CITY, STATE, ZIP CODE	12/2 1/	2012
NAME OF F	PROVIDER OR SUPPLIER	2			OURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION	INDI	ANAPOL	IS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	(F.	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	plan of care in	ncluded "assess for					
	dehydration (d						
	`	ng, change in mental					
	_	sed urine output,					
		urine cracked lips, cry					
	mucus membi	ranes and electrolyte					
	imbalance)."						
	Upon admission the resident was						
	assessed with a feeding tube and						
	had physician	orders for a "free					
	water boluses	400 ml [milliliters]					
	every six hou	rs."					
	_	of the medication					
		n record [12-2012],					
		scribed the order as					
	"200 ml every						
		12-19-12 at 8:25 a.m.,					
		e employee #7 verified					
		200 c.c. [cubic					
	centimeters] e	every 4 hours."					
	Observation of	on 12-19-12 at 9:55					
		Director of Nurses in					
	l '	e resident's skin was					
		d. The urine in the					
		eter tubing was dark					
	and appeared	· ·					
	11		1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 42 of 86

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUILDING	00	COMPLETED 12/21/2012
		.55110	B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	12/2 // 2012
NAME OF F	PROVIDER OR SUPPLIEI	₹		HARCOURT RD	
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION	INDIA	NAPOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE
	Interview on	12-19-12 at 1:00 p.m.,			
		f Nurses verified the			
	color of the resident's urine. The				
	nursing staff f	failed follow the			
	physician ord	er for the free water			
		he resident did not			
	receive the rec	quired amount of			
	hydration which was 2200 c.c. of				
	free water bolus.				
	Review of the	metabolic profile			
	collected on 1	2-19-12 at 7:36 a.m.			
	with the resul	ts received at the			
	facility on 12-	-19-12 at 13:55 [1:55			
	p.m.] indicate	d the resident's			
	sodium level	was 153 [normal			
	range of 126 -	· 146], BUN [blood			
		at 30 [normal range			
	7 - 18].				
	ĺ , , , , , , , , , , , , , , , , , , ,	ne resident had a			
	* *	er, dated 12-18-12 at			
	_	ch instructed the			
	_	to "keep [oxygen]			
		el above 90 %,			
		ters with 28 %			
	1	eep saturation greater			
		ange duonebs [a			
	respiratory tre	eatment] to every 4			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 43 of 86

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MUI A. BUILD B. WING		NSTRUCTION 00	(X3) DATE (COMPL 12/21/	ETED
	PROVIDER OR SUPPLIE	R IRSING AND REHABILITATION		8181 HA	ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		th and perform an ation level every					
	the resident's level on 12-1 12:00 p.m. C 12-19-12 at 2 Assistant Direction attendance we change in corrections.	oxygen saturation 9-12 at 8:00 a.m. and observation on :30 p.m., with the ector of Nurses in ith resident had a indition in which the en saturation level was					
	reviewed on Diagnoses inc limited to der aphasia, urina history of pre dysphasia, an feeding tube These diagno	If for Resident "C" was 12-17-12 at 12:50 p.m. cluded but were not mentia, hypertension, ary retention, diabetes, ssure ulcers, indwelling catheter, a and a tracheostomy. sis remained current the record review.					
	data set asses	e resident's minimum sment, dated 10-02-12 resident required total					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 44 of 86

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 1/2012	
	PROVIDER OR SUPPLIER JRT TERRACE NUI	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CO ARCOURT RD APOLIS, IN 46260	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
		rsing staff of all rities of daily living.				
	care dated 10- resident was " mouth] and no mouth." Inter	resident's plan of 03-12 indicated the NPO [nothing by eds extra care to ventions to this plan ed "oral care every as needed."				
	p.m., the resid During this as resident's lips cracked. Who mouth "strings	were dry and slightly on the resident opened s of thick mucus" I between the surface				
	of care dated (indicated "restareas <sic> to buttock." Interestand turn side to the resident here.</sic>	ad a subsequent plan 07-27-12 which ident has an open right and left ervention to this plan ed "blue chux on bed, so side while in bed." ad a subsequent f care dated 10-03-12				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 45 of 86

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIEI JRT TERRACE NU	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	in which the rewith "pressure Interventions included "assist to reposition of positioning we promote side." Observation of resident remains 10:30 a.m. un Additional obthe resident returned to left positioned und from 8:30 a.m. This Federal to complaints IN	esident was assessed e ulcer." to this plan of care st/encourage resident frequently, use of edge while in bed to to side positioning." on 12-18-12 the ined on back from til 1:00 p.m. servation on 12-19-12 emained slightly side with a pillow der the left upper arm, a. thru 2:30 p.m. ag relates to	TAG		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 46 of 86

NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260			TED		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0312 SS=G	RESIDENTS A resident who is activities of daily necessary service nutrition, groomin hygiene. Based on obse and record reversided to ensur hygiene needs residents who perform activited did not received services. In addition the emergency roomersident ["B"] received at the department with incontinent broomer poor oral hygical condition whice excortaition and testicles for a service of sampled resident ["B", "D" and "Findings inclusions."	ith a saturated ief, uncleanliness, ene, poor skin ch included dulceration of the resident ["B"] for 3 of idents. [Residents 'C"].	F03	12	F312 ADL Care Provided for Dependent Residents It the practice of this provide to ensure that resident who is unable to carr out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	er a is y of	01/16/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 47 of 86

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149		LDING	00	COMPLI 12/21/2	
		100140	B. WIN		A DADAGO CITAL CONTROL	12/2 1//	2012
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		2 17 12 at 1:20 to an		TAG			DATE
		2-17-12 at 1:30 p.m.			personal and		
		eluded but were not			oral hygiene.		
	limited to dial	petes mellitus,			,		
	pancreatic dis	order, hypertension,			What corrective action(s) will be accomplished for those	1	
	traumatic brain injury, chronic obstructive pulmonary disease and				residents found to have beer	,	
					affected by the deficient		
	hypertension. These diagnoses remained current at the time of the				practice · Resident B no long		
					resides at the facility Reside D's activities of daily living (AD		
					care plan and resident care sh		
	record review	-		were reviewed and updated.			
			Resident is receiving ADL per				
	Review of the	resident's minimum			plan of care and as needed.		
	data set assess	sment dated			Resident C's activities of daily living (ADL), care plan and		
		icated the resident			resident care sheet were		
	Í .	nsive assistance from			reviewed and updated. Reside		
					is receiving ADL per plan of ca	are	
		aff for hygiene needs.			and as needed. How will you identify other residents having	, a	
	In addition, th	e assessment			the potential to be affected b	_	
	indicated the i	resident was			the same deficient practice a	-	
	frequently inc	ontinent of urine.			what corrective action will be	•	
					taken · Residents who receive	_	
	Review of the	resident's current			Activities of Daily Living (ADL's have the potential to be affected		
					by the alleged deficient practic		
		originally dated			Nursing staff will be re-educa	ited	
		icated the resident			on ADL's including resident ca		
	had a "self car	re deficit related to			practices by January 16, 2013 the Staff Development	ру	
	TBI [traumati	c brain injury],			Coordinator/designee.		
	diabetes, hypertension, seizure				DNS/designee to monitor for		
					compliance.Rounds will be		
	disorder and depression. [Resident] ADL's [activities of daily living] may fluctuate due to disease				conducted by DNS/desingee of all shifts to ensure residents w		
					receiving ADL Care per plan o		
					careWhat measures will be p		
	processes."				into place or what systemic		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 48 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012	
HARCOL		RSING AND REHABILITATION	STREI 8181 INDI	ET ADDRESS, CITY, STATE, ZIP CODE HARCOURT RD ANAPOLIS, IN 46260	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	included "inconeeded, set up equipment in When the resist the local area room on 11-2 record indicate assessed with diaper soaked and small ulconditional horizolders, ulcers poor skin confucers, ulcers extreme diaper rash, pland came with Interview detaworker] was a [emergency dimedical doct in the content of the conten	dent was evaluated at hospital emergency 2-12, the hospital ed the resident was "poor oral hygiene, in urine, diaper rash er on testicle." spital notation dated cated the "patient was poor oral hygiene, dition/decubitus on testicles, and er rash. Physical esent - Pt. [patient] testicles, extreme oor dental hygiene in a soaked diaper." Tails "SWer [social		changes you will make to ensure that the deficient practice does not recur. Nursing staff will be re-educed on ADL's including resident of practices by January 16, 201 the Staff Development. Noncompliance with the facility policy and procedures may rein employee education and /ordisciplinary action. A Nurser rounds sheet will be completed each shift to ensure residents receiving ADL care per plant or care and as needed. Director Nursing Services/designee with monitor for compliance. How corrective action(s) will be monitored to ensure the deficient practice will not reine., what quality assurance program will be put into plate. A Resident Care Rounds of tool will be utilized weekly a 4 monthly a 2, and quarterly thereafter for one year. Data be submitted to the CQI committee for follow up. If a 95% threshold is not achieve action plan will be developed Completion Date: January 12013	are 3 by ty esult or e ed s are of or of ill the cur, ce? CQI d, a will d, an

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVI COMPLETED	EY	
AND FLAN	OF CORRECTION	155149		LDING	00	12/21/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COL	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	IPLETION DATE
	physical cond	ition - pt. lives in					
	Harcourt Terr	ace nursing home and					
	has TBI. Pt's	[family member]					
	reported 'has r	never seen pt's					
	hygiene this b	ad in the past.' ED					
	MD is admitti	ng pt to the hospital					
	-	t due to current					
		tion. Endangered					
	, ,	t - Potential APS					
		ve services] report					
		fter information is					
		further assessment is					
	commpleted <	<sic>."</sic>					
	The hearitel m	acound funth on					
	The hospital r						
		SWer spoke with the nistrator regarding pt's					
	· ·	al status and poor					
	skin condition	•					
	Skiii condition	mygiche.					
	2. The record	d for Resident "D"					
		on 12-19-12 at 9:40					
	a.m. Diagnos	es included but were					
	_	ischemic heart					
	disease, Alzhe	eimer dementia,					
	coronary arter						
	hypertension,	and a pressure ulcer.					
	These diagnos	ses remained current					
	at the time of	the record review.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 50 of 86

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155149	B. WING		12/21/2012
	PROVIDER OR SUPPLIEI	RSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE HARCOURT RD NAPOLIS, IN 46260	•
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	RIATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	data set assess 11-26-12, ind required exter hygiene needs	icated the resident nsive assistance with			
	Review of the	resident's current			
	plan of care, of	originally dated			
	11-21-12 indi	cated the resident had			
	a "self care de	eficit." Interventions			
	to this plan of	care included "set up			
	hygiene/grooi	ning equipment			
	within easy re				
	-				
	Observation of	on 12-17-12 at 2:20			
	p.m., the resid	lent was seated in			
	_	ljacent to room. The			
		gernails were long and			
	_	nail tip was an			
	abundance of	-			
	substance.				
	3. The record	d for Resident "C"			
		on 12-17-12 at 12:50			
		ses included but were			
	not limited to				
		aphasia, urinary			
		petes, history of			
	i i cicinion, diai	occo, motory or			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 51 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUI	LDING	00	COMPLET: 12/21/20	
		100149	B. WIN			12/21/20	112
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD		
HARCOL	JRT TERRACE NUF	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	re C	COMPLETION DATE
		s, dysphasia, an		_			
	^	heter, a feeding tube					
	and a tracheos	,					
		ained current at the					
	time of the rec						
	inne of the fec	old leview.					
	Davious of the	resident's minimum					
		ment, dated 10-02-12					
		resident required total					
		rsing staff of all					
	aspect of activ	rities of daily living.					
	Review of the	resident's current					
		riginally dated					
		cated the resident had					
	a "self care de						
		ression, hypertension,					
	· · · · · · · · · · · · · · · · · · ·	eimer's, aphasia and					
		he goal for this plan					
		ed the "resident will					
	· ·	y groomed and					
		priately daily through					
	next review."	Interventions					
	included "enco	ourage resident to do					
	as much for se	elf as possible. Praise					
	efforts at self	care. provide shower					
	two times per	week, partial bath in					
	_	p hygiene/grooming					
	equipment in a						
	1 1 1	J					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 52 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	for adverse efficiency of the right, as the resident's left appeared to be yellowish skin the foot. On the left foot were which measure.	resident is at risk fects of a or hypoglycemia of glucose lowering d diagnosis of tus." Interventions to re included, "Weekly nt, pay particular e feet." In 12-18-12 at 1:00 Director of Nurses urse employee #3 in eresident's feet were extensive patches of The resident's left orse condition than e bottom of the			
	inch in length	and width. Interview			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 53 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155149	B. WIN			12/21/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
HARCOL	IRT TERRACE NI I	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260		
			1		711 OLIO, 111 40200		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	with the Direc	ctor of Nurses					
	indicated the	areas were the result					
	of where the t	hick dried skin had					
	come off of th	ne surface of the					
	resident's foot	. Further interview,					
		f Nurses indicated the					
	resident neede	ed staff to lotion feet.					
	Review of a s	ubsequent plan of					
		-03-12 indicated the					
		NPO [nothing by					
	_	eeds extra care to					
		ventions to this plan					
		ted "oral care every					
	shift and prn [as needed."					
		10 10 10 10					
		on 12-19-12 at 2:30					
		lent was assessed.					
	During this as	ssessment, the					
	resident's lips	were dry and slightly					
	cracked Whe	n the resident opened					
	 mouth "string	s of thick mucus"					
	_	d between the surface					
	of the upper a						
	or the upper a	na lower ups.					
	This Federal t	ag relates to					
	Complaint IN	•					
	Complaint IIV	00121013.					
	3.1-38(a)(3)(A	A)					
		,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 54 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

155149 B. WING	12/21/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD HARCOURT TERRACE NURSING AND REHABILITATION INDIANAPOLIS, IN 46260	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	(X5) COMPLETION DATE
3.1-38(a)(3)(C) 3.1-38(a)(3)(E) 3.1-38(b)(1)	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 55 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			A. BUILD B. WING	ING	NSTRUCTION 00	(X3) DATE S COMPL 12/21/	ETED
	ROVIDER OR SUPPLIER	RSING AND REHABILITATION		8181 HA	DDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0314 SS=E	PRESSURE SOF Based on the cona resident, the factor resident who enterpressure sores do sores unless the condition demons unavoidable; and sores receives ne services to promoting to the developing. Based on recommendate a reside of existing operation of excoriation for sampled for preservice and the prevention of excoriation in [Residents "B"] Findings inclusion. 1. The record reviewed on 1 Diagnoses incommendate to diagrams are a resident of the prevention of excoriation in [Residents "B"].	inprehensive assessment of cility must ensure that a cers the facility without the period of the per	F0314	1	F314 Treatment/SVCS to prevent/heal pressure sores It is the practice of this provide ensure that a resident who ent the facility without pressure sor unless the individual's clinical condition demonstrates that th were unavoidable; and a resid having pressure sores receive necessary treatment and servito promote healing, prevent infection and prevent new sore from developing What correct action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident no longer resides at the facility Resident D's chart was review physician orders clarified, care plan updated and resident care sheet updated. Resident is receiving pressure ulcer	eto ers res es ey ent s ces ive d t B	01/16/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 56 of 86

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	V DIII	DINC	00	COMPL	ETED
		155149	A. BUII B. WIN	LDING G		12/21/	2012
		1	D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	I	
NAME OF P	ROVIDER OR SUPPLIE	R			ARCOURT RD		
	JRT TERRACE NU	RSING AND REHABILITATION			IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	hypertension.	These diagnoses			treatment per physician order. Resident E no longer resides		
		ent at the time of the			the facility How will you ident		
	record review				other residents having the		
					potential to be affected by th	ie	
	Review of the	e resident's minimum			same deficient practice and what corrective action will b	_	
					taken? · All residents have the		
		sment, dated 09-19-12			potential to be effected by the		
	indicated the	resident required			alleged deficient practice · A		
	extensive assi	stance with toileting,			sweep has been conducted by		
	hygiene and v	vas frequently			DNS/designee to ensure all		
	incontinent.	vas irequentry			interventions are in place to	-ti	
	incomment.				promote healing, prevent infer and prevent new sores from	Cuon	
					developing · Nursing staff wi	II .	
	The resident's	plan of care dated			be re-educated on skin		
	10-04-11 indi	cated the resident had			management program by		
		eficit. A "goal" to this			January 16, 2013 by the Staf		
					Development · DNS/designed monitor for compliance. What		
	•	licated the "resident			measures will be put into pla		
	will be clean,	neatly groomed and			or what systemic changes ye		
	dressed appro	priately daily"			will make to ensure that the		
					deficient practice does not		
	Interventions	included "incontinent			recur? · Nursing staff will be		
					re-educated on skin		
		d, provide oral care at			management program by January 16, 2013 by the Staf	f	
	least two time	es daily, provide			Development · Skin sweeps		
	shower two ti	mes per week, and			be held monthly ·		
	partial bath in	•			Noncompliance with the facilit		
	Partial outil III				policy and procedures may re		
	A 1	1 6 1 1			in employee education and /o disciplinary action. · A Nurse		
	•	plan of care dated			rounds sheet will be complete		
	08-12-12 indi	cated "problem -			each shift to ensure residents		
	resident has h	/o [history of]			receiving services per plan of		
		integrity to lt. [left]			care · Director of Nursing		
	•				Services/designee will monito		
	ankle and rt. [rightJankle."			compliance. How the correct	ive	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUII	LDING	00	COMPLETED 12/21/2012
		100149	B. WIN		DDDDGG GUTY GTATE TID GODE	12/2 1/2012
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD	
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION			APOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
		to this plan of care		-	action (s) will be monitored to	+
		fy MD of worsening			ensure the deficient practice	
		in wound or for signs			will not recur, i.e., what quali assurance program will be p	-
		ncontinent care as			into place? · A skin	
	· ·	s wound weekly			management program CQI to	l l
	·	measurements and			will be utilized weekly x 4, mor x 2, and quarterly thereafter fo	
					one year. Data will be submitt	ed
	•	bserve for signs of			to the CQI committee for follow up. If 95% a threshold is not	V
		ness, pain, drainage,			achieved, an action plan will be	e
	malodorous di				developed. Completion Date:	
	increase in siz	e/depth of wound."			January 16, 2013	
	continued to f 11-22-12, who sent to the loc evaluation. When the resin the local area room on 11-22 record indicate assessed with	blood glucose levels luctuate through en the resident was al area hospital for dent was evaluated at hospital emergency 2-12, the hospital ed the resident was "poor oral hygiene, in urine, diaper rash				
ı	and small ulce	_				
		spital notation dated				
		cated the "patient was				
	_	poor oral hygiene,				
	poor skin cond	dition/decubitus				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 58 of 86

	OF CORRECTION OF CORRECTION 155149	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	ulcers, ulcers on testicles, and extreme diaper rash."			
	During record review on 12-19-12 at 9:30 a.m., the "shower report" dated 11-21-12 indicated the resident had "redness and raw" noted. The comment section of this report indicated "redness with no open areas." Interview on 12-19-12 at 1:10 p.m. the Assistant Director of Nurses indicated the physician should have been notified for a treatment order. "I was not made aware that on 11-21-12 the area was red or raw. If I had know, yes it would have required the doctor to be notified for a treatment order."			
	2. The record for Resident "D" was reviewed on 12-19-12 at 9:40 a.m. Diagnoses included but were not limited to ischemic heart disease, Alzheimer dementia, coronary artery disease, hypertension, and a pressure ulcer. These diagnoses remained current at the time of the record review.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 59 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING B. WING		12/21/2012
PROVIDER OR SUPPLIER				
JRT TERRACE NUI	RSING AND REHABILITATION			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
had a plan of of which indicate at risk for skir impaired mob chair/bed, dial incontinence, and pressure a Interventions	ed the "resident was a breakdown due to ility, slides down in betes, heart disease, confusion, anemia area to the sacrum."			
12-07-12 instr staff to "clean normal saline calo [calmose] santyl to wour gauze, secure daily and prn The resident w local wound c	ructed the nursing se sacrum with and pat dry, apply ptine] to periwound, and bed, cover with with tape, change [as needed]."			
	SUMMARY S' (EACH DEFICIEN REGULATORY OR The record inchad a plan of a which indicate at risk for skir impaired mobic chair/bed, dial incontinence, and pressure a Interventions included "prevordered." Review of a particular properties of the calo [calmose] santyl to wour gauze, secure daily and prn of the calo grand pressure and pressure an	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The record indicated the resident was treated by a local wound care company. The record indicated the resident had a plan of care dated 11-21-12 which indicated the "resident was at risk for skin breakdown due to impaired mobility, slides down in chair/bed, diabetes, heart disease, incontinence, confusion, anemia and pressure area to the sacrum." Interventions to this plan of care included "preventative treatment as	DENOVIDER OR SUPPLIER JET TERRACE NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (JEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The record indicated the resident was treated by a local wound care company. The record indicated the "resident was at risk for skin breakdown due to impaired mobility, slides down in chair/bed, diabetes, heart disease, incontinence, confusion, anemia and pressure area to the sacrum." Interventions to this plan of care included "preventative treatment as ordered." Review of a physician order dated 12-07-12 instructed the nursing staff to "cleanse sacrum with normal saline and pat dry, apply calo [calmoseptine] to periwound, santyl to wound bed, cover with gauze, secure with tape, change daily and prn [as needed]." The resident was assessed by the local wound care specialist on	OF CORRECTION 155149 DROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (ICACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The record indicated the resident was treated by a local wound care company. The record indicated the "resident was at risk for skin breakdown due to impaired mobility, slides down in chair/bed, diabetes, heart disease, incontinence, confusion, anemia and pressure area to the sacrum." Interventions to this plan of care included "preventative treatment as ordered." Review of a physician order dated 12-07-12 instructed the nursing staff to "cleanse sacrum with normal saline and pat dry, apply calo [calmoseptine] to periwound, santyl to wound bed, cover with gauze, secure with tape, change daily and prn [as needed]." The resident was assessed by the local wound care specialist on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 60 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155149	B. WIN			12/21/	2012
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACTION SHOULD BE O TO THE APPROPRIATE	
	normal saline barrier cream to wound bed moistened, flu	eanse wound bed with and pat dry. Apply to periwound. Santyl followed by hydrogel ffed gauze, then gauze and secure I soiled."					
	Observation on 12-19-12 at 10:30 a.m., licensed nurse employee #8 indicated she was preparing to complete the dressing change to the resident's pressure ulcer.						
	fully dressed. with the help of resident to the slacks to ankle of the incontinuthe resident's left.	ying on back in bed The licensed nurse of a CNA turned the right side, pulled es, removed one side nent brief, exposing outtocks. The ot have a dressing to					
	reviewed on 1 Diagnoses inc	for Resident "E" was 2-18-12 at 10:30 a.m. luded but were not biratory failure,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 61 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			(X2) MULTIPLE CONSTRUCTION A. BUILDING O			(X3) DATE SURVEY COMPLETED 12/21/2012	
		155149	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	12/2 1/20	12
NAME OF F	PROVIDER OR SUPPLIEF	2			ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)			
	congestive he	art failure, chronic					
	obstructive pu	Ilmonary disease, and					
	anoxic injury.						
	In addition the	e resident had a					
	gastrostomy for	eeding tube, an					
		theter, a rectal tube					
	and a tracheos	stomy.					
	TT1 1:	1					
	These diagnoses remained current at the time of the record review.						
	at the time of	the record review.					
	Observation o	n 12-18-12 at 1:35					
		lent was observed for					
	1 *	nent. With the					
	Director of Nu	urses in attendance					
	and licensed n	nurse employee #3 the					
	resident was t	urned to the right					
	side. Observa	tion at this time, the					
	resident was in	ncontinent of stool					
	and a saturate	d dressing was					
	observed on the	ne posterior of the					
	resident's left	thigh.					
		nurses progress					
		2-17-12 at 4:29 p.m.					
		'resident had a small					
		with a bandage on left					
		. Area is closed					
	however with	potential to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 62 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
THEFTERN	or condition	155149	A. BUII B. WIN	LDING	12/21/2012		
NAME OF P	ROVIDER OR SUPPLIER		D. WIIV		DDRESS, CITY, STATE, ZIP CODE		
					ARCOURT RD		
		RSING AND REHABILITATION			APOLIS, IN 46260	1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)				TE	DATE
	breakdown."	Review of the					
	nursing admis	sion assessment,					
	dated 12-17-1	2 at 3:20 p.m., also					
	indicated the r	resident had a					
	"pressure sore	- left buttock cheek."					
	Review of the						
		re Plan," dated					
		35 p.m., indicated the					
		actual impaired skin					
		tion) left buttock					
		vention to this plan of					
		"notify the MD					
	[medical docto	or] as needed."					
	The nursing st	aff failed to notify					
	the physician	for a treatment order					
	until 12-18-12	at 1:00 p.m., when					
	the Director of	f Nurse indicated the					
	physician pres	scribed Calmoseptine					
	every shift and	d as needed."					
	This Federal to						
	Complaint IN	00120868.					
	3.1-40(a)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 63 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	155149	A. BUILDING 00			COMPLETED 12/21/2012	
		.001.10	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	. = . =	
NAME OF P	ROVIDER OR SUPPLIER			l	ARCOURT RD		
HARCOU	IRT TERRACE NUI	RSING AND REHABILITATION		INDIANAPOLIS, IN 46260			
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
F0323 SS=G	483.25(h) FREE OF ACCID HAZARDS/SUPE The facility must denvironment remained curre hazards as is possessive adequate assistance device. Based on obsessive and record revisited to ensure resident's were which resulted bruising and some substance of the formal for falls in a sate [Residents "D"] for 2 of 4 for falls in a sate [Residents "D"]. The record reviewed on 1 Diagnoses incommended in the fall of the fall	ENT RVISION/DEVICES ensure that the resident ains as free of accident sible; and each resident e supervision and es to prevent accidents. ervation, interview riew, the facility re dependent e free from accidents d in a head injury, welling [Resident d resident's reviewed ample of 6. " and "C"]. de: for Resident "D" was 2-19-12 at 9:40 a.m. luded but were not emic heart disease, mentia, coronary hypertension, and a These diagnoses ent at the time of the	F03		F323 Accident and Supervision It is the practice of thisprovider ensure the resident's environmeremains as free of accidenthazards as is possible and each resident receives adequate supervision andassistance devices to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D was reviewed by the IDT team fall prevention and intervention the care plansand residents needs sheets were updated. Resident C was reviewed by the IDT team fall prevention and intervention the care plansand residents needs sheets were updated H will you identifyother resident having the potential to be affected by the same deficient practice and what	r to nent e ent d for ns, for ns,	01/16/2013
		ment, dated 11-26-12			corrective action will be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 64 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155149	B. WING	NO		12/21/	2012
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEI	₹			ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION	INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	Т	ΓAG	DEFICIENCY)		DATE
	indicated the resident required				taken · All residents have the potential to be affected by the		
	extensive assistance with bed mobility and transfer. However the				alleged deficientpractice. Nurs	sina	
					Staff have been re-educated on		
	_	nad a history of falls			thefall management program,		
		•			mechanical lifts by SDC/design	nee	
	_	on and a current plan			by January 16,2013. C.N.A.s were skills validated on		
	of care dated	11-21-12 indicated			mechanical lifts What		
	the resident w	as at "risk for falls			measures will be putinto place	ce	
	due to age his	story of fall, various			or what systemic changes yo		
	_	•			will make to ensure that the		
	medications, i				deficientpractice does not		
	impaired bala	nce, use of			recur · Nursing Staff have bee	en	
	wheelchair, us	se of mechanical lift,			re-educated on the fall		
	noncompliance	ce confusion			management program, and mechanical lifts by SDC/design	nee	
	_				by January 16, 2013. C.N.A.s		
	psychotropic				were skills validated on		
	antihypertensi				mechanical lifts. All residents a	at	
	hypoglycemia	ı."			risk for falls will be reviewed		
					quarterly and significant change		
	Interventions	to the plan of care			ensure appropriate/intervention are in place by the	IIS	
		-			IDTteam. During review of fall	ls.	
	included prev				the IDT will physically investiga		
	[09-07-12] cra	adle mattress, mat on			theresident's room to determin	ie	
	floor, bed aga	inst wall, and gripper			root cause of fall. Fall	41	
	_	-12] call light in			interventions will be implement basedon root cause. Staff who		
		-			arenoncompliant may be	·	
	reach, non ski				re-educated and /or receive		
		ectric high/low bed in			disciplinary action up to		
	lowest position	n, cradle mattress,			andincluding		
	and the most current dated [12-02-12 composure mattress, 2				termination. Director of Nursing		
					Services/designee will monitor compliance. How the	IUI	
					correctiveaction(s) will be		
	_	d resident on right			monitored to ensure the		
	side and bed a	ılarm."			deficient practice will not		
					recur,i.e., what quality		

	OF CORRECTION OF CORRECTION 155149	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/21/2012		
	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	Observation on 12-17-12 at 2:20 p.m., the resident was observed seated in wheelchair adjacent to room. The resident had bruising and slight swelling over the right eyebrow." Review of the progress notes dated 12-10-12 indicated "resident bed alarm went off, aide went in to check on resident <sic> writer was called in by the aide to observe resident. Resident was observed facing down, lower extremities on the floor mat, upper extremities on the bare floor. The bed was in it's lowest position at the time of fall. Bruise on the upper right eyebrow, round at approx. [approximately 3.5 cm. [centimeters] in diameter, 0.9 inch in length <sic> area not opened." The progress notes indicated the resident had a subsequent fall on 12-12-12 at 9:13 a.m. "Prior to fall resident was in bed. Staff was alerted to room by sounding of PAB [personal alarm]. Staff</sic></sic>		assurance program will be pinto place? The fallsmanagement CQI tool will utilized weekly x 4, monthly x 2 quarterlythereafter. The CQI committeewill review the data. a 95% threshold is not achiev an actionplan will be developed. Noncompliancewifacility policy and procedure mresult in employee education and/ordisciplinary action up to and including termination. Compliance date: January 16 2013	be 2, If ed, th		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 66 of 86

	OF CORRECTION IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012			
	PROVIDER OR SUPPLIER JRT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	observed resident on floor next to bed lying on back on floor mat. Current interventions "bed against wall, floor mat, craddle <sic> bed, high low/bed, call light and personals in reach, 2 pillows behind resident on right side, bed alarm."</sic>						
	Review of physician orders, dated 09-06-12 instructed the nursing staff for a "scoop mattress on bed at all times." A current physician order, dated 12-07-12 indicated "low loss air mattress with bolsters due to wound on sacrum."						
	Observation on 12-19-12 at 10:30 a.m., the resident did not have the bolsters on the low loss air mattress.						
	The resident had two falls from the bed, one which resulted in a head injury with swelling and bruising.						
	2. The record for Resident "C" was reviewed on 12-17-12 at 12:50 p.m. Diagnoses included but were						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 67 of 86

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIP A. BUILDING B. WING		NSTRUCTION 00	(X3) DATE (COMPL 12/21/	ETED		
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	not limited to hypertension, retention, diab pressure ulcer indwelling cat and a tracheos diagnosis remetime of the recent lime aspect of active and was sever impaired. Review of the care, dated 10 resident was "impaired balant hypertension, psychosis, decay awareness second limited limes and limited lim	dementia, aphasia, urinary petes, history of s, dysphasia, an heter, a feeding tube atomy. These ained current at the cord review. resident's minimum ament, dated 10-02-12 resident required total rating staff of all rities of daily living ely cognitively resident's plan of -14-12, indicated the at risk for falls due to nee, depression, diabetes, aphasia, creased safety	TAC				DATE	
	medication, us	ses w/c for mobility, all transfers and						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 68 of 86

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149 A. BUILDING	DATE SURVEY COMPLETED 12/21/2012	
B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER 8181 HARCOURT RD		
HARCOURT TERRACE NURSING AND REHABILITATION INDIANAPOLIS, IN 46260		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
recent history of falls."		
Interventions to this plan of care		
included "observe for fall factor's		
and remove if possible, call light in		
reach, hoyer life with 2 staff assist		
for transfers, low bed, personal		
items in reach."		
Review of the physician progress		
notes, dated 10-08-12 indicated "Pt		
had recent fall on 10-05 [2012]		
without injuries noted. Continue		
fall precautions/interventions per		
protocol."		
Review of physician orders dated		
10-14-12 at 2:00 p.m., indicated		
and instructed the nursing staff		
"ordered low air loss mattress with		
bolsters, education of staff on		
positing <sic>, standard neuro</sic>		
check per facility."		
A subsequent physician progress		
note dated 10-15-12, indicated "fall		
- no injuries noted."		
Review of the facility "event		
report" dated 10-14-12 at 5:00 p.m.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 69 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPLI	ETED			
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
TAG	indicated the fivil witnessed, and resident, the releft side. A requestion on the intervention (si to prevent and "teaching was members about the progress of fall indicated found in room to get writer to room, writer side with face forehead was can. Teaching and other staff of patient." Interview on 1 p.m. a concernindicated "the out of bed two can't even more I talked with the administrative of the side with the out of the side with the administrative of the side with the	fall was not d upon finding the esident was lying on esponse to the e event form "What) was put into place other fall," indicated given to all aids/staff at proper positioning." Inote related to this "Res. [resident] was a by CNA. CNA ran to help. Upon entering aw res. lying on left towards the ground, resting on top of trash g was given to CNA f about repositioning 12-17-12 at 12:47 hed family member y let [resident] fall times. [Resident] we by [resident] self. hem [in regard to e staff] and they said	TAG	DEFICIENCY		DATE		
	tney were som	ry for the mishap."						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 70 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155149	A. BUIL		00	12/21/	
		100110	B. WINC		ADDRESS, CITY, STATE, ZIP CODE	12/2 1/	
NAME OF P	PROVIDER OR SUPPLIER	2			ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION	INDIANAPOLIS, IN 46260				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)]	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1710	REGUENTORT OR	LESC IDENTIFIEND IN ORNIZITION		1710			BATE
	Interview on 1	12-18-12 at 1:30 p.m.,					
		ator indicated she did					
	not have a rec						
		of the fall which					
	occurred on 10						
	occurred on IV	U-UJ-12.					
	3 Observatio	on on 12-19-12 at 9:45					
		t "D" was being					
	ŕ	om bed to wheelchair					
		rified Nurses Aide]					
		The CNA positioned					
		e mechanical lift					
	_	sident while the					
		n bed, attached the					
		etal frame of the lift,					
		and control moved					
		o from the bed, and					
	_	tire lift toward the					
	middle of the						
	· ·	ving the resident up					
	ŕ	at to the resident					
	· ·	ere the wheelchair					
		nd then positioned					
		r beneath the resident.					
	· ·	er repeated efforts to					
	_	esident over the					
	middle of the						
	eventually lov	vered the resident into					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 71 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149			LDING	NSTRUCTION 00	(X3) DATE COMPL 12/21/	ETED		
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	indicated the restaff members Review of the 12-19-12 at 11 "Mechanical I original date of 03-201 following: "Procedure Statype]: Two (2 all times where lift. 18. Roll from bed and One staff show other staff open During intervitation 12:30 p.m. the	Resident Care Sheet, resident required 2 for transfer. facility policy on 1:05 a.m., titled Lift," dated as the of 02/2012 and review 2 indicated the 1:05 taff is required at a using a mechanical the lift slowly away toward the chair. 19. The shear the lift." ew on 12-19-12 at the Administrator NA admitted she to resident the expectation of the properties of the proper						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 72 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149 NAME OF PROVIDER OR SUPPLIER		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD		ETED			
		RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CV MUST BE PRECEDED BY ELLL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
F0327 SS=E	483.25(j) SUFFICIENT FLU HYDRATION The facility must sufficient fluid into hydration and her Based on reconstructive the ensure the hydresidents who risk for dehydresidents sample of 6. I and "E"]. Findings inclusion. 1. The record reviewed on 1 Diagnoses incoming the diagnoses incoming the diagnoses incoming the diagnoses at the time of the resident has a sufficient to demand the sufficient	rd review and facility failed to dration needs of were identified at ration for 3 of 3 pled for hydration in a Residents "C", "D" ade: for Resident "C" was 2-17-12 at 12:50 p.m. luded but were not nentia, hypertension, ry retention, diabetes,	F03		F327 Sufficient fluid to maintain hydration. It is the practice of thisfacility to ensure that each resident has sufficie fluid intake to maintainproper hydration and health. What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice? Resident C had an hydration assessment comple by Nursing and assessed by the RD. Residents hydration need are being met perplan of care. Resident D had anew hydration assessment comple by Nursing and assessed by the RD. Residents hydration need are being met perplan of care. Resident E nolonger resides at the facility How will you identifyother residents having the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the potential to be affected by the alleged deficient practice. Nursing were re-educated on the hydration program and enteral	nt new ted he ds ted he ds	01/16/2013
	dated 11-06-1				_	е	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 73 of 86

STATEMENT	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OI	F CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLET	
		155149	B. WIN	G		12/21/20	012
NAME OF PR	OVIDER OR SUPPLIE	R	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TVAINE OF TR	OVIDER OR SOLVER				ARCOURT RD		
HARCOUF	RT TERRACE NU	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	•		DATE
	with 300 c.c. [cubic centimeters]				SDC/designeeAll residents what are identified for risk of	10	
	every four ho	urs."			dehydration were reviewed to		
					ensure residents are receiving		
	Davious of the	e 11-2012 medication			adequate fluides based on die	etary	
					recommendations. What		
	administration	n record contained			measures will be putinto pla		
	documentatio	n on only two			or what systemic changes y	ou	
	separate dates	s related to the			will make to ensure that the deficientpractice does not		
	-	itional hydration,			recur · Nursing were re-education	ated	
		•			on the hydration program and		
		n 1120 c.c., and			enteral therapyphysician orde		
	11-20-12 witl	n 960 c.c. of fluids.			by the January 16, 2013 by		
					SDC/designee A Nurse round		
	The resident	was admitted to the			sheet will be completed each to ensure residents arehydrat		
					needs are being met · A		
		pital on 12-03-12 due			hydration assessment by nurs	sing	
	to a feeding to	ube malfunction.			will be completed quarterly an	nd	
	Further review	w of the hospital			with a significant		
	notes, dated 1	2-03-12 indicated the			change· NurseManagers/desi e will audit the MAR/TAR's to	gne	
	*	hypernatremia likely			ensure compliance of		
1		31			physicianorders for hydration		
	secondary to	denydration.			needs. Staff who		
					arenoncompliant may be		
	Review of the	e hospital laboratory			re-educated and /or receive		
	results indica	ted the resident's			disciplinary action up to andincluding		
		was 151, with normal			termination. Director of Nursir	na	
					Services/designee will monito		
	range of 135	- 145.			compliance. How the		
					correctiveaction(s) will be		
	The hospital i	nursing staff			monitored to ensure the		
	*	intravenous fluids at			deficient practice will not recur,i.e., what quality		
1					assurance program will be p	out	
	•	our and "free H2O			into place? · A hydration CQI		
	[water] flushe	es after re-insertion of			will be utilized weekly x 4, mo		
	the feeding tu	be."			x 2, quarterly thereafter. · The	e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155149	B. WINC	ì		12/21/	2012
NAME OF P	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOTT EIEF				ARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					CQI committeewill review the data. If a 95% threshold is no	ıt.	
	The resident r	eturned to the facility		achieved, an action plan willbe			
	on 12-07-12.				developed. Noncompliancewi		
					facility policy and procedure m	ay	
	2 The record	for Resident "D" was			result in employee education and/ordisciplinary action up to		
		2-19-12 at 9:40 a.m.			and including termination.		
					Compliance date: January 16	6,	
	_	luded but were not			2013		
		nemic heart disease,					
	Alzheimer dei	mentia, coronary					
	artery disease.	, hypertension, and a					
	pressure ulcer	. These diagnoses					
	*	ent at the time of the					
	record review						
	lecold leview	-					
	m i						
		dicated the resident					
	was at "risk fo	or dehydration" and					
	had a physicia	n order dated					
	11-21-12 to "s	start 120 c.c. water					
	with each med	d. [medication] pass					
	and document						
		nsumed in MAR					
	-						
	[medication a	aministration					
	record]."						
	Review of the	resident's plan of					
	care originally	dated 11-21-12					
	, ,	resident was at risk					
		on due to "UTI					
	_						
	Lurinary tract	infection] and use of					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 75 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155149	B. WIN			12/21/2	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	02.0, 10200		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	antibiotic ther	apy, assist with food,					
	DM [diabetes mellitus] and						
	confusion."						
	Interventions 1	to this plan of care					
		vide 120 ml water					
		l pass and document					
	in MAR ml co	_					
		nibunioa.					
	Review of the	current MAR for					
	12-2012 lacke						
		astruction to the					
	nursing staff f						
	^ *	er, and further lacked					
	documentation						
		ds provided by the					
	_	and received by the					
	resident.						
	3. The record	for Resident "E" was					
	reviewed on 1	2-18-12 at 10:30 a.m.					
	Diagnoses inc	luded but were not					
	limited to resp	oiratory failure,					
	_	art failure, chronic					
	_	lmonary disease, and					
	anoxic injury.	•					
		e resident had a					
		eeding tube, an					
	-	theter, a rectal tube					
	i muwening cat	incici, a rectar tube					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 76 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155149	B. WIN			12/21/	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
HARCOL	IRT TERRACE NI II	RSING AND REHABILITATION			ARCOURT RD APOLIS, IN 46260		
			1	<u> </u>		1	(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	and a tracheos	stomy.					
		,					
	These diagnos	ses remained current					
	_	the record review.					
	at the time of	the record review.					
	Observation	on 12-18-12 at 1:35					
	_	lent was observed for					
		nent. With the					
		urses in attendance					
		nurse employee #3 the					
	resident was t	urned to the right					
	side. Observa	ation at this time, the					
	resident was in	ncontinent of stool					
	and a saturate	d dressing was on the					
		ne resident's left thigh.					
	•	was observed with an					
		theter in which the					
	_	e was light yellow in					
	color.	c was fight yellow in					
	COIOI.						
	TT 1	.1 · 1 .					
	•	on the resident was					
		a feeding tube and					
	physician orde	ers for a "free water					
	boluses 400 m	nl [milliliters] every					
	six hours."						
	Upon review of	of the medication					
	-	n record [12-2012],					
		scribed the order as					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 77 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155149	B. WIN			12/21/	2012
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD		
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1.10		six hours. Interview		1110			
	on 12-19-12 at 8:25 a.m., licensed						
		ee #7 verified the					
	order as "200						
		every 4 hours" rather					
	_	ician ordered 400 c.c.					
	every four ho						
		~~ ~•					
	Observation o	on 12-19-12 at 9:55					
		Director of Nurses in					
	1	e resident's skin was					
		d. The urine in the					
	_	eter tubing was dark					
	and appeared						
		12-19-12 at 1:00 p.m.,					
		f Nurses verified the					
		esident's urine. The					
		failed follow the					
	_	er for the free water					
		he resident did not					
	ĺ .	quired amount of					
		ch was 2200 c.c. of					
	free water bol						
	1100 ,, 4101 001						
	Review of the	metabolic profile					
		2-19-12 at 7:36 a.m.					
		ts received at the					
		-19-12 at 13:55 [1:55					
		d the resident's					
	p.m.j maicate	u me restuent s					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 78 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		A. BUILDING B. WING	COMPLETED 12/21/2012		
	ROVIDER OR SUPPLIER	SING AND REHABILITATION	8181 H	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
IAU	sodium level w range of 126 -	vas 153 [normal 146], BUN [blood at 30 [normal range	IAG		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 79 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETE			ETED	
		155149	A. BUII B. WIN			12/21/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	ARCOURT RD		
HARCOU	IRT TERRACE NUF	RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
F0465 SS=E	TABLE ENVIRON The facility must p sanitary, and com residents, staff an	provide a safe, functional, fortable environment for nd the public.					
		ervation and interview	F0465		F465		01/16/2013
		led to ensure a		It is the practice of the facility		0	
	comfortable en	nvironment for			provide a safe, functional,		
	residents and s	staff for 3 of 3			sanitary, and comfortable environment for residents, staf	ff	
	nursing units of	observed.			and the public. What	II.	
	Findings inclu	de:			correctiveaction(s) will be accomplished for those residents found to have beer affectedby the deficient	1	
	1. Willow Ber	nd Nursing Unit -			practice? Room 17-the		
		andrails throughout			doorhas been re-painted, completed on January 10, 201	3	
	this Unit were	worn and without a			The common areain front of t	the	
	finish. The do	oor framing along the			nurses station was re-painted January 7, 2013 · The Oxygo		
		rs lacked paint and			Room door and areas on both		
		numerous to count.			sides wererepainted on Janua 7, 2013 · The Housekeeping closet was cleaned on January		
	this occupied a dangling from track. The pri multiple splatt substance.	e privacy curtain in resident room was the metal ceiling vacy curtain had ters of a pink-red			7,2013. · Auguste's Cottage doors were repainted on Janua 9,2013. · Employee lounge—tl boxes were removed December 18,2012. · The refrigerator in employee lounge was cleanedDecember 18, 2012 · microwave in the employee lounge was cleanedDecember 18, 2012 · The paper towels at counter in the employee	ary he er the The	
		e door to the resident			loungewas cleaned on Decem	ber	
		tched surfaces which			18, 2012. · Cedar Bay-The		
	extended the e	entire width of the			pantry door was repainted on January10, 2013 and the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLETED
		155149	B. WIN			12/21/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹			ARCOURT RD	
HARCOL	JRT TERRACE NU	RSING AND REHABILITATION			APOLIS, IN 46260	
						(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	DATE
1710		LESC IDENTIFIEND IN ORMATION		1710	handrails will be refinished by	DATE
	door.				January 14, 2013 · The door to	
					the "Spa" was repainted on	
	The common area in front of the				January9, 2013 How will	
	nurses station	was a plastered area			you identify other residents	
		-			having the potentialto be	
	· ·	paint. The area			affected by the same deficier	nt
	measured 12 i	nches by 12 inches.			practice and what corrective	
					action will be taken. · No residents were identified. · All	
	"Oxygen Roo	m" - during			areas will be cleaned and	
		n 12-18-12 at 12:55			repaired by January 16, 2013	
					What measureswill be put in	to
	p.m. had a pla	stered area on both			place or systemic changes y	ou
	sides of the lo	wer 1/3 of the door.			will make to ensure that the	
	The areas lack	xed a painted surface.			deficient practice does not	
	Tille areas laet	ied a painted sarrace.			recur. · common areas/employee lounge will be	
					put on a daily cleaning schedu	
	"Housekeepın	g Closet" - This door			Maintenance Director/designer	
	was found unl	locked. There was a			will make daily rounds and rep	ort
	build up of the	e black substance			findings to the Executive Direct	
	•	es of where the wall			Housekeeping & Maintenance staff will bere-educated to ens	
					the facility is safe, functional,	ure
		ace joined. This area			sanitary and a comfortable	
	spanned appro	eximately 3 inches to			environment for residents	
	1 inches in va	rious areas of this			andstaff · Maintenance Director	or
	room Water	was observed on the			will follow Preventative	:-
		was observed on the			Maintenance program for repa and update. How	ıır
	floor.				thecorrective action(s) will be	<u> </u>
					monitored to ensure the	
	2. Auguste's	Cottage - The secured			deficient practice willnot recu	ır,
	door to this de	ementia unit were			i.e., what quality assurance	
	observed with	scratches which			program will beput into place	
					Maintenance Directorwill ma	
		rface of the door. The			daily rounds and report finding the Executive Director.	S TO
	areas spanned	the entire width of			Maintenance Director will follo	w
	the doors.				Preventative	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 81 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	а. вілі	LDING	00	COMPLE	TED
		155149	B. WIN			12/21/2	.012
NAME OF B	ADOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			8181 H	ARCOURT RD		
		RSING AND REHABILITATION			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATION OF THE CONTROL OF THE CONTRO	ΓE	COMPLETION DATE
1110	REGELITORIOR	ESC IDENTIFICAÇÃO AND ORGANIZAÇÃO		1710	Maintenanceprogram for repai	r	Dille
	2 5 1 Oh				and update. An environmenta		
		lounge - Observation		/safety CQI will be completed			
	on 12-17-12 a	t 2:10 p.m., this			weeklyX 2, Monthly X 2 and		
	lounge contair	ned 30 boxes of			quarterly thereafter The Eld designee is responsible for the		
	~	n about the floor.			completion of the Environment		
					CQI tool weekly times 4 weeks	3,	
	The material and	an in 4hia 1aan 1a - 1			bi-monthly times 2 monthsand		
	_	or in this lounge had			then quarterly until continued compliance is maintained for 2		
	dried spillage along the bottom and				consecutive quarters. The rest		
	door shelves.				of these audits will be reviewed		
					by the CQI committee oversee		
	The microway	ve had baked/cooked			by the ED. If a 95% threshold		
					not achieved an action plan wi be developedto ensure		
		all 3 inside surfaces			compliance. Completion		
	including the t	top and bottom			date:January 16, 2013		
	surface. A no	otation taped to the					
	top of the mic	rowave instructed the					
	-	NOTE: wipe down					
		e when you are done					
		e when you are done					
	using it."						
	Paper towels u	used and new were					
	strewn across	the counter surface.					
	4 Cedar Bay	- Adjacent to the					
	,	J					
		was the "pantry."					
		f the door had scuffed					
	and marred su	rface and scratches					
	too numerous	to count. The					
	 wooden handr	ails throughout this					
		n and without a					
	omi were wor	ii and without a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet Page 82 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DESCRIPTION STREET S	(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING B. WING		12/21/2012
			ADDRESS, CITY, STATE, ZIP COD	DE
	ROVIDER OR SUPPLIER	8181 H	ARCOURT RD	
HARCOL	IRT TERRACE NURSING AND REHABILITATION	INDIAN	IAPOLIS, IN 46260	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	
ING	finish.	17.0		DATE
	iiiisii.			
	The door to the "SPA" was scuffed			
	and also had scratches too			
	numerous to count.			
	numerous to count.			
	Interview on 12-07-12 at 2:30 p.m.,			
	the Administrator agreed the first			
	thing she noticed was the condition			
	of the door frames of the resident			
	rooms.			
	TOOMS.			
	3.1-19(f)			
	3.1-17(1)			
			I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 83 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155149		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 12/21/2012				ETED	
	ROVIDER OR SUPPLIE	R IRSING AND REHABILITATION		8181 HA	ADDRESS, CITY, STATE, ZIP CODE ARCOURT RD APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F0514 SS=E	SSIBLE The facility must each resident in professional star are complete; ac readily accessib organized. The clinical recoinformation to id of the resident's care and service any preadmission the State; and professional states and professional states are and service any preadmission the State; and professional states are and service any preadmission the State; and professional states are and service any preadmission the State; and professional states are and service any preadmission the State; and professional states are any preadmission to destruction record rooms Findings includes are also as a state of the states are also as a state of the	re records from loss for 1 of 1 medical observed.	F051	4	F514 Clinical Records It is the practiceof this provide maintain clinical records on earesident in accordancewith accepted professional standar and practices that are complet accurately documented; readi accessible; and systematically organized. What corrective action(s) willbe accomplishe for those residents found to have been affected by thedeficient practice? No residents wereidentified. Med records wasin-serviced on maintaining eachresidents clinical record accurately, read accessible and systematically organized. How will you identifyother residents havin the potential to be affected by the same deficient practice as	ds ds de: ly d d lily g y	01/16/2013

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 84 of 86

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
155149		B. WING		12/21/2012		
				ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIER	8		HARCOURT RD		
HARCOL	JRT TERRACE NUI	RSING AND REHABILITATION		NAPOLIS, IN 46260		
(X4) ID	CLIMMADY C	TATEMENT OF DEFICIENCIES	ID	<u> </u>	(V5)	
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION	
TAG	`		TAG	CROSS-REFERENCED TO THE APPROPRIATE		
TAG	,		TAG	what corrective action will b	DATE	
	cabinets. The	boxes had		taken? · Residents residing in		
	handwritten description of the			facility have the potential to be		
	contents which included resident			affected bythe alleged deficien		
				practice. The cardboard boxes		
	discharge records, resident trust			were removed on January 8,		
	funds, facsimiles to physician			2013 from the medicalrecords		
	· ·	± •		room. What measures will be		
	offices, QA [quality assurance]			putinto place or what systemic		
	files, falls reports, skin log, incident			changes you will make to		
	logs, physician order forms			ensure that the		
	[completed] d	documentation related		deficientpractice does not		
	to resident pharmacy and laboratory			recur · Medical Recordswill be	-	
	•			stored in a professional stand	ard	
	results, and en	nployee files.		that is accurately documented, readily accessible	0	
				and systematically	c	
	2 1 50(4)			organized. The MedicalReco	rds	
	3.1-50(d)			clerk or ED will audit the medi		
				records storage room weekly		
				toensure records are stored		
				properly. How the corrective		
				action(s)will be monitored to)	
				ensure the deficient practice		
				will not recur, i.e., whatquali	-	
				assurance program will be p		
				into place · The MedicalReco		
				clerk or ED will audit the medi	cai	
				records storage room weekly toensure records are stored		
				properly. If issues are identif	ied	
				an action plan will bedevelope		
				ensure compliance.The Medic		
				Director/ED will monitor that the		
				medical records storage area	to	
				ensure the deficient practice of		
				not recur. A Medical Records		
				CQI audit tool will be used		
				weekly for 12 months to ensu	re	
				the medical records are		
				organized and stored		
			ı		I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 85 of 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/04/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155149	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI			
	PROVIDER OR SUPPLIER	RSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	PPROPRIATE	(X5) COMPLETION DATE		
				appropriately Compliar January 16, 2013	nce date:			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WD0511

Facility ID: 000070

If continuation sheet

Page 86 of 86